KANSAS DEPARTMENT FOR AGING AND DISIBILITY SERVICES
HEALTH OCCUPATIONS CREDENTIALING
612 S. Kansas Ave
Topeka, KS 66603-3404

EMPLOYMENT VERIFICATION FORM

NURSE AIDE: COMPLETE THIS SECTION

Social Security Number _____/_____/_____ Date of Birth ___/___/___ CNA ID#_____

Name_____
(Last) (First) (M.I.)

Other Names Used _____

Address _____
(Street) (City/State) (Zip)

Phone Number (Home) _____ (Work) _____

Signature _____ Date _____

EMPLOYER: COMPLETE THIS SECTION

***Only complete this form for the aide listed above if they have performed CNA duties which would include but are not limited to bathing, feeding, lifting, transferring, and vitals.**

Employer's name and mailing address: _____

_____

_____

Telephone number (____) _____

Comments: _____

I certify that the nurse aide named above is/was employed by me to perform nursing or nursing related services from

_____ to _____

Signature _____ Date _____

Title _____

Fax number: 785-296-3075 Web site: www.kdads.ks.gov

Revised 09/21/2017